Supreme Court, U.S.
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No. 00-1021

In the

Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC.,

Petitioner,

v.

DEBRA C. MORAN and STATE OF ILLINOIS,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

BRIEF FOR RESPONDENT STATE OF ILLINOIS

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QUESTION PRESENTED

Section 4-10 of the Illinois Health Maintenance Organization Act provides that if a patient's primary care physician deems medically necessary a proposed procedure the patient desires, but the HMO disagrees and denies coverage for the procedure, the patient may have the HMO's decision reviewed by an outside physician, and the HMO must abide by the reviewing physician's determination. The Seventh Circuit held in this case that this independent review mechanism was not preempted by the Employee Retirement Income Security Act ("ERISA").

The question presented is:

Whether the independent review provision of the Illinois HMO Act, which is similar to laws adopted in forty other States and the District of Columbia, is preempted by ERISA.

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STATEMENT OF THE CASE

1. The Illinois Health Maintenance Organization Act

In 1974, the Illinois General Assembly enacted Public Act 78-1151, the Health Maintenance Organization Act ("Act" or "HMO Act"), which is codified at 215 Ill. Comp. Stat. 125/1-1 *et seq*. (2000). The Act defines an HMO as an organization that provides, or arranges and pays for, or reimburses the cost of basic health care services from providers it selects under a system that causes the organization or its providers to bear some part of the risk of health care delivery. 215 Ill. Comp. Stat. 125/1-2 (2000). Among other things, the Act imposes general corporate and financial requirements for all HMOs in Illinois. *See, e.g.*, 215 Ill. Comp. Stat. 125/2-1 to 3-1 (2000). It also sets forth certain medical services that HMOs must provide, including "medically necessary services associated with the administration of a drug" for treatment of certain types of cancer. 215 Ill. Comp. Stat. 125/4-6.3 (2000).

In 1987, the General Assembly amended the HMO Act to address concerns about the operation of HMOs in Illinois. 85th Ill. Gen. Assembly, House of Rep. Proceedings, June 24, 1987 at 233 (comments of Rep. Shaw). One concern was that an HMO enrollee "had nowhere to go" when an HMO refused to provide treatment that the enrollee's primary care physician considered necessary. *Id*. To address this concern, the General Assembly enacted Public Act 85-20, which includes the independent review provision now found at section 4-10 of the HMO Act. 215 Ill. Comp. Stat. 125/4-10 (2000).

Section 4-10 applies when there is a dispute between an HMO enrollee's "primary care physician and the

Health Maintenance Organization regarding the medical necessity of a covered service proposed by a primary care physician." *Id.* Section 4-10 requires all HMOs to provide a mechanism for resolution of such disputes by a physician who is not affiliated with the HMO and who holds the same class of license as the primary care physician. *Id.* The primary care physician, the HMO, and the patient jointly select the reviewing physician. *Id.* If the reviewing physician determines that the covered service proposed by the primary care physician is medically necessary, the HMO must provide the service.[1] 215 Ill. Comp. Stat. 125/4-10 (2000).

2. Ms. Moran's Claim

In January 1998, respondent, Debra C. Moran, sought to invoke her statutory right to independent physician review under section 4-10 in a complaint filed in the Circuit Court of Cook County, Illinois against petitioner, Rush Prudential HMO, Inc. ("Rush"). JA 12-14. Ms. Moran was covered by a medical benefits plan through her husband's employer, and Rush was the plan's HMO

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[1] Under the Illinois Managed Care Reform and Patient Rights Act, which became effective January 1, 2000, the enrollee may seek external independent review of any Managed Care Organization's ("MCO") decision to deny treatment on the ground that the treatment is not medically necessary even if there is no dispute between the enrollee's primary care physician and the MCO about this issue. 215 Ill. Comp. Stat. 134/45(f) (2000). The Managed Care Reform and Patient Rights Act was not in effect at the time of the relevant events in this case. This act did not repeal or amend section 4-10 of the HMO Act, which remains in effect.

provider. Pet. App. 3a. The dispute between Rush and Ms. Moran arose from treatment she sought in 1996 for pain, numbness, decreased mobility, and loss of function in her right shoulder. *Id.* Ms. Moran's primary care physician was Dr. Arthur LaMarre, who was affiliated with Rush. *Id.*

Dr. LaMarre prescribed physiotherapy and other conservative therapies for Ms. Moran, but her symptoms did not subside. *Id.* at 3a-4a. Ms. Moran then traveled to Virginia at her own expense to see Dr. Julia Terzis, a specialist in microreconstructive surgery. *Id.* at 4a. Dr. Terzis diagnosed Ms. Moran as suffering from brachial plexopathy and thoracic outlet syndrome ("TOS"), a syndrome resulting from the compression of nerves in her brachial plexus. *Id.* Dr. Terzis recommended that Ms. Moran undergo a surgical procedure consisting of removal of the uppermost rib and the attached muscle and, if indicated during the course of the procedure, microneurolysis of the lower roots of the brachial plexus under intraoperative microscopic magnification. *Id.* After she returned home from Virginia, two thoracic surgeons affiliated with Rush examined Ms. Moran and recommended instead the standard surgical procedure for TOS, which does not involve microneurolysis. *Id.* at 5a.

Ms. Moran decided, however, that she wished to have the surgical procedure recommended by Dr. Terzis. *Id.* On October 14, 1997, Dr. LaMarre sent a letter to Rush stating that Ms. Moran would be "best served" by having Dr. Terzis' proposed surgery and asking Rush to approve the procedure. *Id.* Rush denied the request and after Ms. Moran appealed internally Rush affirmed the denial of coverage on the ground that the procedure was not "medically necessary" under the plan's definition of that term. *Id.* Rush's Membership Advisory Committee upheld the

denial after Ms. Moran made her final internal appeal to that body. *Id.*

In January 1998, Ms. Moran sent Rush a written demand for independent external review of the coverage denial in accordance with section 4-10 of the Illinois HMO Act. *Id.* Rush did not act on this request, and Ms. Moran filed her complaint in the Circuit Court of Cook County, Illinois later that month. *Id.* In the complaint, she asked the court to order Rush to agree to the appointment of an independent reviewing physician pursuant to section 4-10 to consider the medical necessity of the surgery proposed by Dr. Terzis. JA 14. Rush removed the complaint to the United States District Court for the Northern District of Illinois, but the district court remanded the case to the state court because Ms. Moran's action did not involve a federal claim. Pet. App. 7a. In the meantime, Dr. Terzis performed the microneurolysis surgery upon Ms. Moran, and she incurred costs of $94,841.27. *Id.* at 6a.

The Circuit Court of Cook County entered an order on November 2, 1998 granting in part Ms. Moran's motion for judgment on the pleadings and directing Rush to provide independent review pursuant to section 4-10 of the HMO Act regarding the medical necessity of the surgery performed by Dr. Terzis. JA 15-16. Rush complied with this order, and the independent review was performed by Dr. Lee Dellon, who specialized in plastic and reconstructive surgery at the Johns Hopkins Medical Center. Pet. App. 7a. Dr. Dellon concluded that the surgery performed by Dr. Terzis was medically necessary, although he indicated that he would have used a different technique in performing the microneurolysis. Pet. App. 8a.

After Dr. Dellon finished his independent review, Rush again considered whether Ms. Moran's surgery was covered, and it denied the claim again in January 1999. *Id.* Ms. Moran then amended her complaint to add allegations that Rush had declined to pay for her surgery despite the independent reviewer's conclusion that it was medically necessary. *Id.* at 20-21; JA 17-22. Ms. Moran sought a judgment directing Rush, among other things, to pay for the cost of her surgery and post-operative care. JA at 21-22.

After Ms. Moran amended her complaint, Rush removed the case to federal court a second time. Pet. App. 8a. Ms. Moran sought a remand to state court, but the district court denied her motion on the basis that her claim for reimbursement arose under federal law because it was a claim for plan benefits that fell within § 502(a)(1)(B) of the civil enforcement provision of the Employee Retirement Security Income Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a)(1)(B). Pet. App. 8a-9a, 38a-43a. In the order denying remand, the district court also concluded that section 4-10 of the Illinois HMO Act was not saved from preemption by ERISA's "savings" clause, which provides that ERISA does not preempt state laws that regulate insurance. 29 U.S.C. § 1144(b)(2)(A). The district court concluded that section 4-10 of the HMO Act was not a law regulating insurance because the provision does not spread or transfer the policyholder's risk. Pet. App. 42a. The district court denied Ms. Moran's motion for reconsideration. Pet. App. 46a.

After her motion to remand to state court was denied, Ms. Moran filed a second amended complaint in which she added a new claim under section 502(a) of ERISA, 29 U.S.C. § 1132(a). JA 23. Rush moved for summary

judgment, and the district court granted the motion. Pet. App. 10a. The district court noted that the employee benefit plan gave Rush broad discretion to make benefit determinations, and it ruled that Rush was entitled to summary judgment because it had not abused its discretion or acted in an arbitrary manner in denying Ms. Moran's benefit claim. *Id.*

3. The Seventh Circuit's Decision

Moran appealed to the United States Court of Appeals for the Seventh Circuit. *Id.* at 2a. The Seventh Circuit allowed the State of Illinois to intervene to defend section 4-10 of its HMO Act. *Id.* On October 19, 2000, the court issued a decision reversing the district court and concluding that Ms. Moran rather than Rush was entitled to summary judgment. Pet. App. 1a-24a.

Initially, the Seventh Circuit concluded that Ms. Moran's action was properly removed to federal court because it was a claim under 29 U.S.C. § 1132(a)(1)(B) to enforce her rights under an ERISA plan. Pet. App. 11a-13a. The court went on to conclude that ERISA's insurance savings clause, 29 U.S.C. § 1144(b)(2)(A), applied and saved section 4-10 of the HMO Act because it is a law that regulates insurance as a matter of common sense, and it satisfies two of the three factors traditionally examined in determining whether a state law regulates insurance. Pet. App. 16a-18a. These factors, known as the McCarran-Ferguson factors,[2] are whether the law: (1) has the effect of spreading or transferring the policy-

[2] These factors are used in determining whether a law regulates the "business of insurance" under the McCarran-Ferguson Act. 15 U.S.C. § 1011, *et seq.*

holder's risk; (2) is an integral part of the relationship between the insurer and the insured; and (3) is limited to entities in the insurance industry. Pet. App. 16a-17a. The Seventh Circuit explained that section 4-10 regulates insurance as a matter of common sense because HMOs are insurance vehicles and the provision is "directed to the HMO industry as insurers." Pet. App. 17a.

The court also found that two of the McCarran-Ferguson factors were met. According to the court, the second factor was met because laws like section 4-10 that effectively mandate terms in insurance contracts change the bargain between insurer and insured and are therefore integral parts of the relationship between them. *Id.* at 17a-18a. Section 4-10 also satisfied the third McCarran-Ferguson factor because it was limited to entities in the insurance industry. *Id.* at 18a. Under these circumstances, the court concluded that section 4-10 was a law that regulated insurance within the meaning of the savings clause.[3] *Id.* at 17a-18a.

After determining that the savings clause applied to section 4-10, the court considered whether section 4-10 was nonetheless preempted because it conflicted with ERISA's civil enforcement scheme by providing an alternative remedy. *Id.* at 19a-23a. The Seventh Circuit concluded that section 4-10 does not create an alternative

[3] The Seventh Circuit also held that ERISA's "deemer" clause, 29 U.S.C. § 1144(b)(2)(B), does not apply to section 4-10. Pet. App. at 18a-19a. The court stated that the deemer clause only shields self-funded plans from state laws that regulate insurance, and the plan in this case is an insured plan. *Id.* Rush has not raised an argument based on the deemer clause in its opening brief in this Court.

remedy that conflicts with section 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B), which gives plan beneficiaries and participants the right to sue to recover benefits or to enforce or clarify rights under the plan. *Id.* at 21a-22a. Because the terms of section 4-10 were incorporated into Ms. Moran's insurance contract as a matter of law, the court concluded that her lawsuit to enforce her rights under section 4-10 was an action to enforce her rights and recover benefits under the plan, exactly the type of suit that section 502(a) of ERISA contemplates. *Id.* at 21a. Therefore, section 4-10 does not create a remedy that conflicts with ERISA. Instead, it merely creates an additional mechanism for making decisions about medical necessity when the HMO and the patient's primary care physician disagree. *Id.* at 21a-22a.

The Seventh Circuit acknowledged that its decision on this issue conflicted with *Corporate Health Ins. Co. v. Texas Dept. of Ins.*, 215 F.3d 526 (5th Cir. 2000). Pet. App. at 20a-21a. Because of the conflict, the Seventh Circuit circulated the opinion prior to publication for a vote on whether the case should be heard *en banc*. *Id.* at 23a. A majority of the Seventh Circuit judges voted not to hear the case *en banc*, but four judges dissented from the denial of rehearing *en banc*. *Id.* at 23a-27a.

SUMMARY OF ARGUMENT

ERISA's savings clause states that nothing in the ERISA preemption provision "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A). The savings clause expresses Congress' desire that States retain the authority to regulate the business of insurance. Section 4-10 of the Illi-

nois HMO Act is a law that regulates insurance under the criteria set forth by this Court in several cases. The savings clause therefore applies to section 4-10 and saves it from preemption.

In resolving whether a state law regulates insurance for purposes of the savings clause, the first question is whether the law regulates insurance as a matter of common sense. *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, 367 (1999). The other question is whether the law satisfies the factors used to determine whether a state law regulates the business of insurance under the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.* *UNUM*, 526 U.S. at 373. These factors are guideposts that need not all be satisfied. *Id.* at 374.

Section 4-10 regulates insurance as a matter of common sense. A law regulates insurance as a matter of common sense when it is directed toward the insurance industry. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987). Section 4-10 applies only to HMOs, "entities that are engaged in the business of health insurance." *Washington Physicians Service Ass'n v. Gregoire*, 147 F.3d 1039, 1045 (9th Cir. 1998), *cert. denied*, 525 U.S. 1141 (1999). As the Seventh Circuit concluded here, section 4-10 is "aimed exclusively at members of the insurance industry," and the provision therefore regulates insurance under a common-sense understanding of the matter. Pet. App. 17a-18a.

Section 4-10 also satisfies all three McCarran-Ferguson factors. The first factor is satisfied because the provision transfers risk to HMOs. Because of the independent external review provided by section 4-10, HMO enrollees in Illinois run less risk of having medical services denied on the basis that they are not medically neces-

sary. Section 4-10 achieves the transfer of risk and confers a benefit upon HMO enrollees because they will not have to pay for medical treatment as often as a result of the provision. The second factor is met because laws that change the bargain in an insurance contract by effectively adding contract terms form an integral part of the relationship between the insurer and the insured. *UNUM*, 526 U.S. at 374. Section 4-10 is such a law. The third McCarran-Ferguson factor is met because section 4-10 is limited to entities in the insurance industry, as stated above.

Furthermore, section 4-10 does not conflict with any provision of ERISA so there is no preemption on this basis. The independent external review requirement of section 4-10 does not conflict with the remedial scheme set forth in section 502(a) of ERISA, 29 U.S.C. § 1132(a). Section 4-10 merely provides for an additional review mechanism when an HMO and an enrollee's primary care physician disagree about whether treatment is medically necessary. This review mechanism is similar to binding arbitration, and federal circuits have consistently concluded that mandatory arbitration provisions in employee benefit plans do not conflict with ERISA. *See, e.g., Kramer v. Smith Barney*, 80 F.3d 1080, 1084 (5th Cir. 1996) (citing cases).

Unlike the common-law rule at issue in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 49-50 (1987), section 4-10 does not create a cause of action or a new remedy for the denial of plan benefits. But, because the right to independent external review set forth in section 4-10 is effectively incorporated into all HMO coverage in Illinois as a matter of law, this right may be pursued in an action brought under section 502(a)(1)(B) of ERISA.

There is also no conflict between section 4-10 and the requirement of "full and fair" internal fiduciary review of adverse benefit claim determinations set forth in section 533 of ERISA, 29 U.S.C. § 1133. Section 4-10 does not supplant the requirements of section 533 in any manner. Instead, section 4-10 adds the requirement of external review under certain circumstances. Section 4-10 of the HMO complements rather than contradicts section 533 of ERISA, which is intended to protect plan beneficiaries.

Finally, the savings clause unambiguously exempts state laws regulating insurance like section 4-10 from ERISA preemption without exception. When a statute is unambiguous, the judicial inquiry about its meaning is at an end, and the provision should be enforced as written. *Connecticut Nat'l Bank v. Germain*, 503 U.S. 249, 254 (1992). Thus, even if section 4-10 conflicts with an ERISA provision, the savings clause saves the independent external review requirement from preemption.

ARGUMENT

I. INTRODUCTION

The Illinois General Assembly enacted section 4-10 of the Illinois HMO Act to give an HMO enrollee recourse when the enrollee's physician believes medical treatment is necessary but the HMO refuses to provide it. 85th Ill. Gen. Assembly, House of Rep. Proceedings, June 24, 1987, at 233 (comments of Rep. Shaw). Legislative bodies in forty other states and the District of Columbia have passed similar laws requiring independent external review of medical necessity decisions of HMOs under certain circumstances in order to assure that HMO cov-

erage is meaningful.[4] These laws are entirely consistent with ERISA's objective of protecting plan participants and their beneficiaries. 29 U.S.C. § 1001(b).

Rush nonetheless argues that these beneficiaries cannot avail themselves of the protection of independent external review laws like section 4-10 because ERISA preempts them. In making this argument, Rush fails to recognize the presumption that ERISA does not preempt state law when the state is exercising its historic police

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[4] *See* Alaska Stat. § 21.07.050 (Michie 2001); Ariz. Rev. Stat. Ann. § 20-2537 (2000); Cal. Ins. Code § 10169 (2001); Colo. Rev. Stat. § 10-16-113.5 (2000); Conn. Gen. Stat. § 38a-478n (2001); 16 Del. Code Ann. § 9119 (2000); D.C. Code § 32-571.7 (2000); 2000 Fla. Laws ch. 00-256; Ga. Code Ann. § 33-20A-32 (2000); Hi. Rev. Stat. § 432E-6 (2000); 215 Ill. Comp. Stat. 125/4-10 (2000); Ind. Ins. Code Ann. § 27-13-10.1-1 (2000); Iowa Code Ann. § 514J (2000); Kan. Stat. Ann. § 40-22a13 (2000); Ky. Rev. Stat. § 304.17A-623 (2001); La. Rev. Stat. 22:3081 (2000); 24-A Me. Rev. Stat. § 4312 (2000); Md. Ins. Code Ann. § 15-10A-01 (2001); Mass. Ann. Laws Ann. ch. 1760 § 14 (2001); Mich. Comp. Laws § 550.1907 (2001); Minn. Stat. § 62Q.73 (2000); Rev. Stat. Mo. § 376.1385 (2000); Mont. Code Ann. § 33-37-102 (2000); N.H. Rev. Stat. Ann. 420-J:5 (2000); N.J. Stat. § 26:2S-11 (2001); 13 N.M. Adm. Code § 10.17.24 (2000); N.Y. Ins. Law § 4904 (McKinney 1999); N.C. Gen. Stat. § 58-50-62 (1999); Ohio Rev. Code Ann. § 1751.84 (Anderson 2001); 63 Okl. St. § 2528.3 (2000); Oregon Laws, ch. 266, § 8 (2001); 40 Pa. Cons. Stat. § 991.2162 (1998); R.I. Gen Laws § 23-17.12-10 (2001); S.C. Code Ann. § 38-71-1970 (2000); Tenn. Code Ann. § 56-32-227 (2001); Tex. Ins. Code art. 21.58A (Vernon Supp. 2001); Utah Code Ann. § 31A-22-629 (2000); 8 Vt. Stat. Ann. § 4089 (2001); Va. Code Ann. § 38.2-5901 *et seq.* (2001); Rev. Code Wash. 48.43.535 (2001); W. Va. Code § 33-25C-6 (2001); Wis. Stat. § 632.835 (2000).

powers. *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995). States have traditionally regulated the business of insurance, as Congress recognized when it enacted the McCarran-Ferguson Act, which provides that federal antitrust laws apply to the business of insurance only to the extent that this business is not regulated by state law. 15 U.S.C. § 1012. Congress also recognized that the regulation of insurance was traditionally a state matter when it enacted ERISA's savings clause, 29 U.S.C. § 1144(b)(2)(A), which exempts state laws regulating insurance from ERISA preemption. *FMC Corp. v. Holliday*, 498 U.S. 52, 63 (1990).

Under section 514(a) of ERISA, state laws are generally preempted if they "relate to any employee benefit plan." 29 U.S.C. § 1132(a); *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, 363 (1999). ERISA's savings clause qualifies this provision by excepting from preemption state laws that regulate insurance, banking, or securities. 29 U.S.C. § 1144(b)(2)(A). This allows states to regulate an insured ERISA plan indirectly by regulating its insurer and the insurer's insurance contracts. *FMC Corp.*, 498 U.S. at 64. As this Court has recognized, documents that create an HMO are not themselves an ERISA plan, but an agreement between an employer and an HMO may set forth elements of an ERISA plan by setting forth rules under which beneficiaries are entitled to medical care. *Pegram v. Herdrich*, 530 U.S. 211, 223 (2000).

The Seventh Circuit held that section 4-10 relates to employee benefit plans, but ERISA does not preempt section 4-10 because the savings clause applies. Pet. App. 14a-23a. This Court should affirm the Seventh Circuit. Section 4-10 of the HMO Act is an exercise by

the Illinois General Assembly of the traditional authority of states to regulate insurance. Consequently, the savings clause excepts section 4-10 from preemption.

II. ERISA DOES NOT PREEMPT SECTION 4-10 OF THE HMO ACT BECAUSE IT IS A STATE LAW THAT REGULATES INSURANCE.

A. The ERISA Savings Clause Saves From Preemption A State Law That Regulates Insurance Even If The Law Has An Adverse Impact On The Uniform Administration of ERISA Plans.

ERISA's savings clause expresses Congress' intent to avoid interference with the traditional powers of the states to regulate the business of insurance. *FMC Corp.*, 498 U.S. at 63. The clause saves from preemption state laws that regulate insurance even if the laws have an adverse impact on the uniform administration of ERISA plans. *UNUM*, 526 U.S. at 376, n.6; *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 722, 746-47 (1985). Nothing in ERISA's language, structure or legislative history supports a more restrictive reading of the savings clause. *Metropolitan Life*, 471 U.S. at 746.

Congress' decision to save from preemption state laws that regulate insurance inevitably causes some lack of uniformity in plan administration. *Id.* at 747. Arguments about the wisdom of this policy decision, however, should be directed to Congress rather than the courts. *Id.* The savings clause applies and saves section 4-10 from preemption if it is a law regulating insurance, even if the independent physician review requirement interferes with the uniform administration of ERISA plans, as Rush contends. Pet. Br. at 26.

B. Section 4-10 Of The HMO Act Regulates Insurance As A Matter Of Common Sense And It Satisfies All Three Factors Used To Determine Whether A Practice Constitutes The Business Of Insurance Under The McCarran-Ferguson Act.

The framework for determining whether a state law regulates insurance within the meaning of the savings clause is well-established. The first step is to consider whether a common-sense understanding of the matter indicates that the law regulates insurance. *UNUM*, 526 U.S. at 367; *Metropolitan Life*, 471 U.S. at 740. The next step is to examine whether the law satisfies the three factors used to determine whether a practice constitutes the business of insurance under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq*. *UNUM*, 526 U.S. at 367; *Metropolitan Life*, 471 U.S. at 740. These three factors are: (1) whether the practice in question has the effect of transferring or spreading policyholder risk; (2) whether the law regulates an integral part of the relationship between the insurer and the insured; and (3) whether the law applies only to entities in the insurance industry. *Metropolitan Life*, 471 U.S. at 743. These factors are guideposts in determining whether a state law regulates insurance; they are not essential elements that must all be satisfied to save the state law from preemption. *UNUM*, 526 U.S. at 373-74.

1. Section 4-10 Regulates Insurance As A Matter Of Common Sense.

State laws that are directed specifically at the insurance industry are laws that regulate insurance from a common-sense perspective. *UNUM*, 526 U.S. at 368.

Section 4-10 of the Illinois HMO Act regulates insurance as a matter of common sense because it applies solely to health maintenance organizations, "entities that are engaged in the business of health insurance." *Washington Physicians Service Ass'n v. Gregoire*, 147 F.3d 1039, 1045 (9th Cir. 1998), *cert. denied*, 525 U.S. 1141 (1999) (savings clause applied to Washington law regulating HMOs and other insurers).

As the court pointed out in *Washington Physicians*, insurance is characterized by the acceptance of risks and the spreading of resulting losses over all the risks so that the insurer can accept each risk at a slight fraction of the possible liability upon the insurer. *Washington Physicians*, 147 F.3d at 1045. The only difference between an HMO and a traditional health insurer is that the HMO provides medical services directly while the traditional insurer does so indirectly by paying for the services, but this is "a distinction without a difference." *Id.* at 1045-46. HMOs essentially operate in the same manner as traditional health insurers; the policyholder pays a fee in exchange for a promise that he or she will receive medical services when necessary. *Id.*

The Sixth Circuit recently cited *Washington Physicians* in support of its conclusion that HMOs are insurers. *Kentucky Ass'n of Health Plans, Inc. v. Nichols*, 227 F.3d 352, 364-65 (6th Cir. 2000), *petition for cert. filed*, No. 00-1471 (savings clause applied to "any willing provider law"). Other circuits have reached the same conclusion. *Express Scripts, Inc. v. Wenzel*, 262 F.3d 829, 835 (8th Cir. 2001) (savings clause applied to Missouri law regulating HMO prescription drug coverage); *Anderson v. Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994) (HMOs are "insurance vehicles under Illinois law"); *In re Medcare HMO*, 998 F.2d 436, 444-45 (7th Cir. 1993) (HMO's

are "the substantial equivalents of domestic insurance companies"); *but see O'Reilly v. Ceuleers*, 912 F.2d 1383, 1389 (11th Cir. 1990) (HMOs are not insurers). Even the Fifth Circuit, which held that a Texas independent external review law was preempted, held in the same case that HMOs are insurers, and the insurance savings clause applied to the challenged provision. *Corporate Health Ins. Co. v. Texas Dep't. of Ins.*, 215 F.3d 526, 537-38 (5th Cir. 2000), *petition for cert. filed*, No. 00-665.

Rush contends that section 4-10 does not regulate insurance as a matter of common sense because the law applies to HMOs even when they are acting solely as third-party administrators of plans, and not as insurers.[5] Pet. Br. at 39. The *amici* supporting Rush echo this argument. *Amicus* brief of American Association of Health Plans, Inc. *et al.*, p. 21. The concerns of Rush and *amici* are unfounded.

The Illinois HMO Act defines a health maintenance organization as "any organization formed under the laws of this or another state to provide or arrange for one or more health care plans under a system which causes any part of the risk of health care delivery to be born by the organization or its providers." 215 Ill. Comp. Stat. 125/1-2 (2000). In light of the Act's definition of the term "health maintenance organization," section 4-10 only ap-

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[5] Although Rush now argues that section 4-10 is too broad to be considered a law regulating insurance, it argued in the Seventh Circuit that section 4-10 was too narrow to qualify as such because it did not apply to all insurers. The Seventh Circuit rejected this argument (Pet. App. 17a), and Rush has not raised the argument in this Court. Rush acted as an insurer here because the plan at issue was an insured plan. Pet. App. 18a.

plies when HMOs are involved in the spreading or transfer of risk, which this Court has recognized as an important characteristic of the business of insurance. *UNUM*, 526 U.S. at 374; *Metropolitan Life*, 471 U.S. at 743. Thus, when HMOs act solely as third-party administrators of a plan and are not involved in the spreading or transfer of risk, section 4-10 does not apply to them.

Rush mentions examples in its brief of HMOs sharing risk with other entities through methods such as capitated arrangement with physician groups, and Rush argues that HMOs are not acting as insurers when they enter into such arrangements.[6] Pet. Br. at 38. But an HMO's transfer of risk to a physician provider group under a capitated contract does not entirely relieve the HMO of risk because it does not relieve the HMO of its contractual obligation to provide health care to its subscribers. *See* Overbay and Hall, *Insurance Regulation of Providers That Bear Risk*, 22 Am. J. L. and M. 361, 372 (1996). For example, in the event the provider group becomes insolvent, the HMO is still obligated to provide health care to its subscribers. *Id.* Thus, an HMO is still bearing risk, and it is still acting as an insurer even when it enters into a risk-sharing arrangement with a third party. Section 4-10 therefore applies to HMOs only when they are acting as insurers.[7]

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[6] For a discussion of capitation and other risk-sharing arrangements employed by HMOs, see Hampton, *Resurrection of the Prohibition on the Corporate Practice of Medicine: Teaching Old Dogma New Tricks*, 66 U. Cin. L. Rev. 489, 506-07 (1998).

[7] The *amici* supporting Rush argue that section 4-10 applies to HMOs that merely act as administrators for self-insured (continued...)

The fact that section 4-10 applies to insurance contracts is a further indication that the provision regulates insurance as a matter of common sense. In this respect, section 4-10 of the Illinois HMO Act has an effect similar to the state laws that were saved from ERISA preemption under this Court's holdings in *Metropolitan Life* and *UNUM*. *Metropolitan Life* involved a Massachusetts statute requiring any general health insurance policy to contain, at a minimum, certain coverage for persons suffering from mental illnesses, including coverage for at least 60 days of confinement in a mental hospital. *Metropolitan Life*, 471 U.S. at 730. This Court held that the savings clause applied to that statute because it regulated the terms of insurance policies and mandated benefits. *Id.* at 742-44. Similarly, in *UNUM*, the Court held that the savings clause applied to a California common-law rule under which an insurer had to show actual prejudice in order to justify denying coverage for

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[7] (...continued)
ERISA plans. *Amicus* brief of American Association of Health Plans, Inc., et al., p. 21. In light of the Illinois HMO Act's definition of "health maintenance organization" discussed above, this argument is without merit. Furthermore, even if section 4-10 did apply to HMOs when they act as administrators of self-insured plans, Illinois could still apply the provision to those HMOs when they act as insurers. ERISA's so-called "deemer" clause, 29 U.S.C. § 1144(b)(2)(B), which states that a benefit plan shall not be deemed an insurance company for purposes of the savings clause, would merely preclude application of section 4-10 to HMOs when they administer self-insured plans. *See Metropolitan Life*, 471 U.S. 724, 735-36, n.14 (1985) (interpreting the deemer clause as exempting self-funded ERISA plans from state laws that regulate insurance within the meaning of ERISA's savings clause).

failure to comply with a policy deadline for providing notice of a claim. *Id.* at 366-67. The Court stated that the California rule effectively created a mandatory contract term under which insurers had to show actual prejudice before they could enforce a timeliness-of-claim provision in an insurance policy. *Id.* at 374.

Likewise, section 4-10 effectively creates a mandatory contract term in HMO coverage in Illinois. Illinois courts apply the general insurance law principle that statutory provisions that apply to insurance contracts become a part of all such contracts as though they were actually incorporated in them. *Plumb v. Fluid Pump Service, Inc.*, 124 F.3d 849, 861 (7th Cir. 1997); *Harris v. St. Paul Fire & Marine Ins. Co.*, 248 Ill. App. 3d 52, 618 N.E.2d 330, 333 (1st Dist. 1993). Thus, as the Seventh Circuit concluded, the provisions of section 4-10 are substantive terms of all HMO coverage in Illinois by operation of law. Pet. App. at 17a. Like the state laws at issue in *Metropolitan Life* and *UNUM*, section 4-10 effectively creates a mandatory contract term. Because section 4-10 is limited to entities in the insurance industry and it applies to insurance contracts, the provision regulates insurance as a matter of common sense. *UNUM*, 526 U.S. at 368.

2. Section 4-10 Satisfies All Three McCarran-Ferguson Factors.

Section 4-10 also satisfies all three of the McCarran-Ferguson factors, although they need not all be satisfied for the savings clause to apply. *UNUM*, 526 U.S. at 374. In *UNUM*, the Court held that the savings clause applied when California's notice-prejudice rule regulated

insurance as a matter of common sense, and it satisfied the second and third McCarran-Ferguson factors. *Id.* at 373-76. The Seventh Circuit correctly reached the same conclusion for the same reason here. Pet. App. at 18a. Section 4-10 satisfies the second McCarran-Ferguson factor, which is whether the provision regulates an integral part of the relationship between the insurer and the insured. *UNUM*, 526 U.S. at 374. In *UNUM*, California's notice-prejudice rule satisfied the second McCarran-Ferguson criterion because it changed the bargain in an insurance contract by effectively creating a mandatory contract term requiring insurers to prove prejudice before they denied coverage on the basis of an untimely claim. *Id.* The rule, therefore, dictated terms of the relationship between the insurer and insured and served as an integral part of the relationship between them. *Id.* at 374-75.

The same is true of section 4-10, which is actually incorporated into HMO coverage by operation of Illinois law and thereby creates a mandatory contract term. *See Plumb*, 124 F.3d at 861. Like the rule at issue in *UNUM*, section 4-10 limits the ability of the insurer, in this case the HMO, to deny coverage under the circumstances specified therein. Because section 4-10 dictates terms of the insurance relationship between HMOs and enrollees, it serves as an integral part of the relationship between them. *UNUM*, 526 U.S. at 374. Section 4-10 also satisfies the third McCarran-Ferguson factor, which is whether the law applies only to entities in the insurance industry. *Metropolitan Life*, 471 U.S. at 743. As discussed above, section 4-10 applies to HMOs only when they are acting as insurers.

Like the *UNUM* Court, the Seventh Circuit found it unnecessary to consider the first McCarran-Ferguson

factor, which is whether the provision achieves the transfer or spreading of risk, because it found that the other two factors were satisfied. Pet. App. at 16a-18a. If this Court decides to address the first factor, it should find that the factor is satisfied because section 4-10 has the effect of transferring policyholder risk to the HMO.

Rush contends that section 4-10 does not transfer risk because it does not affect an enrollee's coverage rights, as Rush is required to pay for medically necessary services under the plan irrespective of section 4-10. Pet. Br. at 41. But, in enacting section 4-10, the Illinois legislature provided that an HMO's decision to deny coverage on the basis that a covered service is not medically necessary will not be the final word on the matter if the patient's primary care physician disagrees with the determination. In that event, an independent physician makes a binding determination as to whether the requested care is medically necessary. 215 Ill. Comp. Stat. 125/4-10 (2000). The Illinois legislature undoubtedly contemplated that there would be situations in which an HMO's denial of coverage on medical necessity grounds would be overturned by the independent reviewing physician. Thus, the Illinois legislature made a conscious decision to transfer a greater degree of risk to HMOs because the independent external review requirement increases the number of situations in which HMOs will be required to pay for medical services because they are medically necessary. Section 4-10 thereby accomplishes the transfer of risk by shifting more risk from the insured to the insurer. *See Washington Physicians*, 147 F.3d at 1046.

Additionally, in arguing that the first McCarran-Ferguson factor is not satisfied, Rush cites *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119, 130-31 (1982), for

the proposition that the insurance policy defines the risk assumed by the insurer and the transfer of risk is completed at the time the parties enter into the insurance contract. Pet. Br. at 40. But Rush overlooks the fact that the independent physician review requirement of section 4-10 became part of the insurance contract at issue here by operation of Illinois law. *Plumb*, 124 F.3d at 861. The provision is therefore part of the insurance contract that defines the risk transferred to the insurer, and it is connected to the spreading of risk achieved by that contract. *See Pireno*, 458 U.S. at 130.

In sum, section 4-10 of the HMO Act regulates insurance as a matter of common sense, and it also satisfies all three McCarran-Ferguson factors. Therefore, as the Seventh Circuit concluded, the ERISA savings clause applies to section 4-10 and saves it from preemption. Pet. App. at 16a-18a.[8]

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[8] Rush has not argued in its opening brief that ERISA's deemer clause (29 U.S.C. § 1144(b)(2)(B)) applies here, and the Seventh Circuit correctly ruled that it does not. Pet. App. at 18a-19a. The Seventh Circuit stated that the deemer clause only shields self-funded plans from state laws that regulate insurance, and the plan at issue in this case is an insured plan. *Id.*, citing *UNUM*, 526 U.S. at 367, n.2.

III. SECTION 4-10 OF THE HMO ACT DOES NOT CONFLICT WITH THE CIVIL ENFORCEMENT SCHEME IN SECTION 502(a) OF ERISA OR WITH ANY OTHER ERISA PROVISION.

A. Unlike The Mississippi Common-Law Rule At Issue In *Pilot Life*, Section 4-10 Does Not Create A Cause Of Action That Provides A Remedy For An ERISA Violation.

The ERISA savings clause reflects that Congress intended to allow dual regulation under ERISA and state insurance law. *John Hancock Life Ins. Co. v. Harris Trust and Savings Bank*, 510 U.S. 86, 100 (1993). Under these circumstances, state law must yield only when there is a direct conflict with federal law. *Id.* There is no such conflict here. The Seventh Circuit correctly rejected Rush's argument that section 4-10 is preempted because it conflicts with the remedies provided in the civil enforcement scheme in section 502(a) of ERISA, 29 U.S.C. § 1132(a).

Among the remedies set forth in section 502(a) of ERISA are the right of a plan beneficiary to sue in order to: (1) recover benefits due under the plan, (2) enforce the beneficiary's rights under the plan, and (3) to clarify his or her right to future benefits. 29 U.S.C. § 1132(a). Section 4-10 of the Illinois HMO Act does not conflict with the remedial scheme prescribed by Congress in section 502(a). Instead, section 4-10 merely requires an additional review mechanism akin to arbitration when an HMO and an enrollee's treating physician disagree about whether treatment for an enrollee is medically necessary. Federal circuits that have considered the issue have consistently concluded that mandatory arbitration provisions in ERISA plans do not conflict with ERISA. *See, e.g., Kramer v. Smith Barney*, 80 F.3d 1080, 1084 (5th Cir. 1996) (citing cases).

Rush relies primarily upon *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) in support of its preemption argument based upon an alleged conflict with section 502(a) of ERISA. The Court held in *Pilot Life* that ERISA preempted a Mississippi common-law cause of action for punitive damages for bad faith in breaching a contract. *Id.* at 45-57. Initially, the Court held that this common-law cause of action related to an employee benefit plan, and it therefore fell within the preemption clause in section 514(a) of ERISA, 29 U.S.C. § 1132(a). *Pilot Life*, 481 U.S. at 47. The Court went on to consider the plaintiff's argument that the ERISA savings clause applied and saved the state-law claim for bad faith as a law that regulates insurance. *Id.* In rejecting this contention, the Court held that the savings clause did not apply because the rule applied to entities outside the insurance industry, and allowed punitive damages whenever an act or omission constituting a breach of contract also constituted an independent tort. *Pilot Life*, 481 U.S. at 49-50. Because "[a]ny breach of contract, and not merely breach of an insurance contract" could result in punitive damages, the rule did not regulate insurance, and the savings clause did not apply to it. *Pilot Life*, 481 U.S. at 50.

By contrast, section 4-10 applies only to HMOs, "entities that are engaged in the business of health insurance." *Washington Physicians*, 147 F.3d at 1045. For this reason, the savings clause applies to the independent physician review provision. Like the California notice-prejudice rule at issue in *UNUM*, section 4-10 is a law "firmly applied to insurance contracts, not a general principle guiding a court's discretion in a range of matters." *UNUM*, 526 U.S. at 371. This factor distinguishes section 4-10 from the common-law cause of action at issue in *Pilot Life*.

The Court also held in *Pilot Life* that ERISA preempted Mississippi's bad-faith cause of action because Mississippi provided a remedy for the wrongful denial of benefits in addition to those provided in ERISA's civil enforcement scheme, 29 U.S.C. § 1132(a), which Congress intended to be exclusive. *Pilot Life*, 481 U.S. at 51-57. Section 4-10 differs from the Mississippi common-law rule in that the independent external review provision does not establish a cause of action in which a remedy such as punitive damages may be awarded for the wrongful denial of ERISA benefits. This factor distinguishes the case at bar from *Pilot Life* and two other cases relied upon by Rush, *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140-45 (1990) (holding that ERISA preempted state common law cause of action for wrongful discharge), and *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 62 (1985) (holding that ERISA preempted state common-law tort and contract claims).

Rush expresses a fear that adoption of the Seventh Circuit's reasoning in this case will permit states to subvert section 502(a) of ERISA by deeming state laws providing remedies that are inconsistent with ERISA's civil enforcement scheme to be plan terms. Pet. Br. at 27a. But the Seventh Circuit's decision does not allow states to evade section 502(a) by "recasting prohibited alternative remedies as mandated contract terms" as Rush contends. Pet. Br. at 28-29. Rush's argument is unfounded because, unlike the state laws at issue in *Pilot Life*, *Ingersoll-Rand*, and *Taylor*, section 4-10 does not create a state-law remedy for the denial of benefits under an ERISA plan.

This case illustrates why section 4-10 does not provide such a remedy. Here, Rush persisted in its refusal to pay for Moran's surgery after the independent reviewing

physician determined that it was medically necessary. Pet. App. 8a. The employment of the independent physician review mechanism did not, by itself, provide any relief to Moran. Instead, even after the review took place, Moran had to pursue her cause of action against Rush for payment of the costs relating to her surgery. The Seventh Circuit concluded that this was a claim for plan benefits that had to be brought under section 502(a) of ERISA, 29 U.S.C. § 1132(a). Pet. App. 13a. But the Seventh Circuit also correctly held that section 4-10 is enforceable in actions brought under section 502(a) of ERISA, citing this Court's decision in *UNUM*. Pet. App. at 21a-23a.

UNUM applies with equal force here. Under the Court's reasoning, the California notice-prejudice rule effectively created a mandatory contract term requiring insurers to prove prejudice before they denied coverage on the basis of an untimely claim. *UNUM*, 526 U.S. at 374. Section 4-10 also creates a mandatory contract term because it is actually incorporated into HMO coverage by operation of Illinois law. *See Plumb v. Fluid Pump Service, Inc.*, 124 F.3d 849, 861 (7th Cir. 1997). Furthermore, this Court rejected the contention in *UNUM* that ERISA preempted the notice-prejudice rule because the rule regulated only the administration of insurance policies and not the substantive policy terms. *UNUM*, 526 U.S. at 375, n.5. Thus, under *UNUM*, the fact that the mandatory contract term created by section 4-10 concerns procedural aspects of claims processing rather than substantive aspects of HMO coverage does not result in preemption.

After concluding in *UNUM* that the ERISA savings clause applied to California's notice-prejudice rule, the Court considered whether the rule was nonetheless

preempted because it conflicted with ERISA. The Court held that section 502(a) of ERISA did not preempt the notice-prejudice rule, noting that the plaintiff had brought suit under section 502(a). *UNUM*, 526 U.S. at 377. The Court concluded that the notice-prejudice rule "supplied the relevant rule of decision for this § 502(a) suit." *Id*. Here, too, Moran brought a claim under section 502(a) of ERISA in her second amended complaint after the district court denied her motion to remand to state court. JA 23. As the Seventh Circuit concluded, section 4-10 forms the relevant rule of decision in this case, just as the state-law rule did in *UNUM*.[9] Pet. App. at 23a. There is no conflict between section 4-10 of the Illinois HMO Act and section 502(a) of ERISA.[10]

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[9] Rush suggests in a footnote that there is a potential problem under Article III of the Constitution because the Seventh Circuit employed state law to resolve a federal claim brought under section 502(a) of ERISA. Pet. Br. at 25, n.6. But the situation here is the same as the one in *UNUM*; a state-law rule formed the relevant rule of decision in both instances. The cases cited by Rush do not hold that this scenario violates Article III.

[10] The *amici* supporting Rush contend that the Seventh Circuit's analysis is inconsistent with *Firestone Tire and Rubber Co v. Bruch*, 489 U.S. 101 (1989). *Amicus* brief of American Association of Health Plans, Inc., *et al*., p. 14. This Court held in *Bruch* that, when a benefit denial is challenged in an action brought under section 502(a) of ERISA, federal courts should apply a *de novo* standard of review unless the plan gives the administrator discretionary authority to determine eligibility for benefits. *Bruch*, 489 U.S. at 115. *Bruch* does not preclude states from enacting laws that effectively prevent HMOs and other insurers from writing policies that grant

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B. Section 4-10 Effectively Requires Binding Arbitration, Which Is Consistent With ERISA.

In arguing that section 502(a) of ERISA preempts section 4-10, Rush states that this independent external review provision effectively requires binding arbitration. Pet. Br. at 22, 31, n.10. Illinois agrees the dispute resolution procedure set forth in section 4-10 is similar to arbitration because section 4-10 provides for the selection of a person who will make a binding determination in a disputed matter, in this case the medical necessity of treatment proposed by an HMO enrollee's treating physician. *See Wauregan Mills, Inc. v. Textile Workers Union of America, AFL-CIO*, 21 Conn. Sup. 134, 146 A.2d 592, 595 (1958) (defining "arbitration"); *Black's Law Dictionary* 105 (6th ed. 1990).

This characterization of section 4-10 hardly helps Rush's cause. Under the Federal Arbitration Act, arbitration clauses in contracts involving commerce are "valid, irrevocable, and enforceable." 9 U.S.C. § 2. Thus, as this Court has recognized, there is a federal policy that favors arbitration. *Shearson/American Express, Inc. v. McMahon*, 482 U.S. 220, 227 (1987); *Moses H. Cone Mem. Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1, 24 (1983).

In *McMahon*, the plaintiffs filed a complaint alleging that the defendants had violated the antifraud provisions in section 10(b) of the Securities and Exchange Act

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[10] (...continued)
them discretion in determining eligibility for benefits. And there is no conflict with ERISA in this context as ERISA does not set forth a standard of review of denials of benefits by a plan administrator.

of 1934, 15 U.S.C. § 78j(b), although the plaintiffs' agreement with the defendant brokerage firm required arbitration of such claims. *McMahon*, 482 U.S. at 223. The plaintiffs argued that the arbitration provision was invalid and relied on provisions of the Securities and Exchange Act granting federal district courts exclusive jurisdiction over violations of that act, 15 U.S.C. § 78aa, and declaring void any condition, stipulation, or provision compelling anyone to waive compliance with any of that Act's provisions, 15 U.S.C. §§ 78cc(a). Despite these provisions, this Court held that the agreement to arbitrate was valid. *Id.* at 227-38.

This Court has not considered whether mandatory arbitration agreements in ERISA plans are consistent with ERISA. Nevertheless, the *McMahon* decision and the federal policy favoring arbitration indicate that section 502(a) of ERISA does not operate as a bar to arbitration of claims for ERISA benefits. In fact, every federal circuit that has considered the issue has concluded that clauses in ERISA plans that require arbitration do not conflict with ERISA. *See Chappel v. Laboratory Corp. of Am.*, 232 F.3d 719, 724-25 (9th Cir. 2000); *Kramer v. Smith Barney*, 80 F.3d 1080, 1084 (5th Cir. 1996); *Pritzker v. Merrill Lynch, Pierce, Fenner & Smith*, 7 F.3d 1110, 1115-16 (3d Cir. 1993); *Bird v. Shearson Lehman/American Express, Inc.*, 926 F.2d 116, 122 (2d Cir. 1991), *cert. denied*, 501 U.S. 1251 (1991); *Graphics Communication Union v. GCIU-Employer Retirement Benefit Plan*, 917 F.2d 1184, 1188-89 (9th Cir. 1990) *Arnulfo P. Sulit, Inc. v. Dean Witter Reynolds*, 847 F.2d 475, 478-79 (8th Cir. 1988). Here, section 4-10 is consistent with ERISA's central purpose, which is protecting plan participants and their beneficiaries. *See* 29 U.S.C. § 1001(b). Section 4-10 protects HMO enrollees by enabling them to receive independent physician review when the enrollee's primary care physician and the HMO disagree about the medical necessity of treatment proposed by the primary care physician.

Rush argues that a different result is warranted here because the "arbitration" requirement set forth in section 4-10 is imposed by state law, and is not voluntarily undertaken by HMOs. Pet. Br. at 31 n.10. In making this argument, Rush ignores the rationale behind the Federal Arbitration Act and the its policy of encouraging arbitration. In enacting this statute, Congress recognized that arbitration is a desirable alternative to litigation in light of the complexities of litigation. *Scherk v. Alberto-Culver Corp.*, 417 U.S. 506, 511 (1974). The Federal Arbitration Act was intended to allow parties to avoid the expense and delays resulting from litigation and to place arbitration agreements on an equal footing with other types of contracts. *Id.* at 510-11. There is no reason why these policies should not apply with equal force in situations where state law dictates the terms of an agreement to arbitrate.

Here, the Illinois legislature has chosen to require HMOs to agree to independent physician review, a form of binding arbitration, when there is a dispute between an HMO and an enrollee's treating physician about the medical necessity of proposed treatment. 215 Ill. Comp. Stat. 125/4-10 (2000). In the course of regulating the business of insurance, states may dictate contract terms to insurers, and those terms become enforceable parts of agreements between the insurers and their insureds. *See UNUM*, 526 U.S. at 374-77; *Metropolitan Life*, 471 U.S. at 742-46. ERISA does not preclude Illinois from enforcing the independent physician review requirement of section 4-10.

C. Section 4-10 Of The HMO Act Does Not Conflict With ERISA's Requirement That Employee Benefit Plans Offer An Opportunity For Full And Fair Review Of A Claim Denial By The Appropriate Named Fiduciary.

Section 503 of ERISA states that, in accordance with regulations of the Secretary of Labor, an employee benefit plan must "afford a reasonable opportunity to any participant or beneficiary whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. § 1133(2). Section 4-10 does not purport to eliminate this requirement of internal fiduciary review in any manner. Instead, it merely adds the separate requirement of independent external review by a physician in the event of a conflict between the HMO and an enrollee's treating physician over the medical necessity of a covered service. This independent physician review only takes place after the "full and fair" fiduciary review required by section 503 of ERISA. Rush's argument that there is a conflict between section 4-10 of the HMO Act and section 503 of ERISA should therefore be rejected.

The primary purpose of ERISA's fiduciary provisions is "to insure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator." *Massachusetts v. Morash*, 490 U.S. 107, 115 (1989). The requirement of full and fair review by a fiduciary set forth in section 503 of ERISA furthers ERISA's goal of protecting plan participants and their beneficiaries. *See* 29 U.S.C. § 1001(b). Section 4-10 of the HMO Act furthers this goal as well. Like the notice-prejudice rule at issue in *UNUM*, section 4-10 "complements rather than contradicts ERISA" by providing additional protection to insured parties. *UNUM*, 526 U.S. at 377.

Rush argues that the independent physician review requirement of section 4-10 is inconsistent with section 503 of ERISA because the independent review is not conducted by a plan fiduciary, as required by section 503. Pet. Br. at 22, n.5. This argument is based upon the premise that the independent review requirement becomes part of the "full and fair review" required under section 503 of ERISA.

Rush's premise is faulty, as the Secretary of Labor recognized in regulatory amendments that will be effective on January 1, 2002. The amendments add several subsections to a regulation that applies to claims procedures and establishes requisites for the "full and fair" fiduciary review required by section 503 of adverse benefit determinations. *See* 65 Fed. Reg. 70,270. Under the new subsection (k)(2)(i) of this regulation, a state law regulating insurance that establishes a procedure to resolve disputes involving adverse benefit determinations will not be preempted by the regulation as long as the person who conducts the review is not the insurer, the plan, a plan fiduciary, the employer, or an agent of any of the same. 65 Fed. Reg. 70,270 (to be codified at 29 C.F.R. § 2560.530-1(k)(2)(i)). The new subsection (k)(ii) provides that state-law external review procedures of the type described in subsection (k)(i) "are not part of the full and fair review required by section 503" of ERISA. 65 Fed. Reg. 70,271 (to be codified at 29 C.F.R. § 2560.530-1(k)(ii)).

The Secretary of Labor's new regulations correctly recognize the distinction between the full and fair internal review required by section 503 of ERISA and the exter-

nal review required by state laws such as section 4-10 of the HMO Act. The new regulatory amendments also recognize that external review laws like section 4-10 are consistent with section 503 although the review is conducted by a person who is not a plan fiduciary. If accepted, Rush's contrary argument would mean that mandatory arbitration clauses in ERISA plans would violate section 503 because the arbitration would not be conducted by a plan fiduciary. Such a result would be inconsistent with the decisions cited above holding that mandatory arbitration clauses in ERISA plans do not conflict with ERISA.

In any event, medical necessity determinations involving ERISA plan beneficiaries need not be made by fiduciaries. *See Pegram v. Herdrich*, 530 U.S. 211 (2000). In *Pegram*, the Court stated that, when medical necessity is at issue, decisions about eligibility for coverage "cannot be untangled from physicians' judgments about reasonable medical treatment." *Id.* at 229. The Court went on to hold that these "mixed eligibility" decisions were not fiduciary acts, and Congress did not intend that any HMO be treated as a fiduciary to the extent that the HMO makes such decisions through its physicians. *Id.* at 229-37. Thus, section 4-10 of the HMO Act does not conflict with ERISA to the extent that it allows independent reviewing physicians who are not acting as fiduciaries to make medical necessity determinations under certain circumstances.

Rush contends that, if ERISA does not preempt section 4-10 and similar laws, plan administrators will be subject to a "patchwork scheme of regulation." Pet. Br. at 29. As the Court has recognized, however, Congress' decision to save from preemption state laws that regu-

late insurance inevitably causes some lack of uniformity in plan administration. *Metropolitan Life*, 471 U.S. at 747. Congress nevertheless chose to allow states to regulate plans indirectly by regulating their insurers directly, *FMC Corp.*, 498 U.S. at 64, as Illinois has done here by enacting section 4-10 of the HMO Act. Section 4-10 is not preempted by ERISA because it is a law that regulates insurance, and it does not conflict with section 502(a) or any other provision of ERISA. To the contrary, this is a case where the state law at issue furthers ERISA's goal of protecting plan beneficiaries and participants. 29 U.S.C. § 1001(b); *Morash*, 490 U.S. at 115 (1989). Section 4-10 "complements rather than contradicts ERISA" and it is saved from preemption by ERISA's savings clause. *See UNUM*, 526 U.S. at 377.

D. Under The Plain Language Of The Savings Clause, Section 4-10 Of The Illinois HMO Act Is Saved From Preemption Even If It Conflicts With One Of ERISA's Other Provisions.

As Illinois has argued above, ERISA's savings clause applies and excepts section 4-10 of the HMO Act from preemption because the provision is a state law regulating insurance and because it does not conflict with any provisions of ERISA. If this Court reaches a contrary conclusion, however, it should nonetheless hold that section 4-10 is not preempted. Under the plain language of the savings clause, the clause would still apply and save section 4-10 from preemption.

The Court indicated in *Pilot Life* that a state law that regulates insurance is still preempted if the law conflicts with a substantive provision of ERISA. 481 U.S. at 54-57. In reaching this conclusion, the Court relied largely

on the legislative history of ERISA. This aspect of *Pilot Life* was not necessary to the Court's holding because the Mississippi common-law rule at issue in that case did not regulate insurance, so the savings clause did not apply to it. *Id.* at 50.

The Court's reliance on ERISA's legislative history was misplaced in light of the language of the savings clause, which states that nothing in the ERISA preemption provision "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A). The savings clause unambiguously exempts state laws regulating insurance like section 4-10 from ERISA preemption without exception. When a statute is unambiguous, the judicial inquiry about its meaning is at an end, and the provision should be enforced as written. *Connecticut Nat'l Bank v. Germain*, 503 U.S. 249, 254 (1992). Therefore, there was no need to consult the legislative history of ERISA in order to ascertain the scope of the savings clause.

Furthermore, the portion of ERISA's legislative history that the Court relied on in *Pilot Life* contains a flawed analogy between ERISA and the federal Labor-Management Relations Act ("LMRA"). The LMRA does not have any statutory exception to preemption similar to ERISA's savings clause, thereby undermining the validity of any analogy between the two statutes.[11] Relying

[11] The Solicitor General of the United States pointed this out in a brief filed in *UNUM*. *UNUM*, 526 U.S. at 376, n.7. The Solicitor General went on to argue in the brief that the ERISA savings clause on its face saves state laws regulating
(continued...)

on this flawed analogy, the Court concluded that section 502(a) of ERISA was intended to have the same preemptive force as section 301 of the LMRA, 29 U.S.C. § 185, which completely displaces any state-law cause of action for the violation of a collective bargaining agreement between a labor organization and an employer, thereby reflecting Congress' intent that federal labor law uniformly prevail over state and local rules. *Pilot Life*, 481 U.S. at 55-56.

Since *Pilot Life*, the Court has emphasized that a presumption exists that ERISA does not preempt state law when the state is exercising its historic police powers. *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995). States have traditionally regulated the business of insurance, as Congress recognized when it enacted the McCarran-Ferguson Act, an act that says federal antitrust laws apply to the business of insurance only to the extent that this business is not regulated by state law, 15 U.S.C. § 1012, and when it enacted ERISA's savings clause, 29 U.S.C. § 1144(b)(2)(A). Remedial provisions designed to address violations are an important aspect of state insurance laws. The savings clause expresses the intent of Congress to avoid interference with the States' power to regulate insurance. *See Metropolitan Life*, 471 U.S. at 740-41. If it is necessary to decide the issue, the Court should hold that the ERISA savings clause saves from preemption state laws that provide remedies. Such a holding would vindicate the states'

[11] (...continued)
insurance that create remedies or causes of action. *Id.* (acknowledging the Solicitor General's argument, but stating that it need not be addressed).

authority to regulate insurance, an authority that Congress expressly sought to preserve when it enacted the savings clause.

CONCLUSION

The judgment of the United States Court of Appeals for the Seventh Circuit should be affirmed.

Respectfully submitted,

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